Interview with CAPT Albert J. Shimkus, Jr., NC, USN, commanding officer of the medical treatment facility aboard hospital ship USNS *Comfort* (T-AH 20). Conducted by Jan K. Herman, Historian of the Navy Medical Department, 12 September 2006, Baltimore, MD.

Where are you from originally?
Hopedale, MA.

Where did you go to grade school?
I went to school in Hopedale, which is in Worcester County. All my years of schooling were done there, unlike our children who have been educated in 6 different school systems.

When did you decide to join the service?
Actually, I didn't decide to join the service but Vietnam and the draft came along. I anticipated a draft notice and wanted to avoid being in the Army so I joined the Air Force. I knew I didn't want to in the Army and knew the Air Force, at that point, had a better quality of life. So I enlisted in the Air Force in August of 1965.

What tech school did you attend?
For some reason I was chosen to be a medic, and the Air Force sent me to Gunter Air Force Base in Alabama. It was 90230, basic AF Medic training. From there I went to Otis Air Force Base for my first assignment to an Air Force hospital, the 551st USAF Hospital.

Almost home.
Yes, almost home, about 50 miles from Hopedale which was really nice. I earned my 90250, mid-level Medic skills at Otis and, of course, that qualified me to go overseas. I then ordered to Vietnam and spent a year at Bien Hoa Air Base. I was there for the Tet Offensive in January of 1968.

What do you recall about that?
I remember it vividly. The last part of that was very interesting. The Viet Cong came in and overran the base. As medical providers, we were very busy doing our work. I did okay, I survived that, and came back from Vietnam in November of '68. I then decided never again to put on a uniform because I didn't care for that kind of life. Instead I went back to college. I had subsequently married my wife, Beth, who I met on Cape Cod prior to going to Vietnam. She joined the Air Force Nurse Corps and was stationed at Travis Air Force Base hospital when I was in Vietnam.

An interesting anecdote: I used to send patients to her with tags on their pajamas with a note because I knew the patient would be transiting through Travis. She was assigned to the casualty staging unit and on her duty days would meet all the arriving injured and/or ill Service members on the flight line. A portion of the injured or ill patients coming from Vietnam came through Travis. So she would get my notes.

Anyway, I got out of the Air Force in '68 and went back to Worcester, MA, to go to school. We lived in veterans' housing. I remember the rent being based on my income, which was $23 a month. We had a son at that point. I was going to school but didn't know what I wanted to do yet.

I decided that maybe nursing would be interesting. Some very good Air Force nurses had been part of my career in Vietnam and at Otis. A friend of mine, Jerry Christy--a medic in Vietnam--decided to go with me to nursing school. We applied to Memorial Hospital School of Nursing in Worcester and started our nursing careers in 1970 at Memorial Hospital as the first two men ever admitted to this hospital based school of nursing.

What was it like being a pioneer?

Not really. At no point--in my Navy career--have I ever felt anything negative with regard to my gender. When I was in nursing school in Worcester the only thing I wouldn't do is wear a hat. At that time, nurses wore hats. I told the director at the school that I wouldn't be wearing a hat and they would have to come up with something else for me to wear. I ended up wearing a patch on my sleeve indicating my year of school. But Jerry and I never felt any kind of gender discrimination whatsoever.

I passed my boards in Massachusetts and went on to Salem State College to obtain a BSN degree. Right after that, I was asked to join the faculty of the Salem Hospital School of Nursing, where I taught for 3 years. That was interesting. It was a wonderful job and I'd still be there today except that the Salem Hospital School of Nursing closed based on the pressure in the nursing profession to earn a baccalaureate degree as an entry level qualification.

That's what led me to the military again. I remembered my time in the Air Force as a very positive time. So we thought, as a family, that it would allow us some stability if we went back into the military.

I first went to the Air Force but was told "We'd like you to come back in the Air Force as a 2nd lieutenant and your first assignment will be Minot, North Dakota."

I said, "That's a very nice idea, but I don't think I want to go to Minot, North Dakota." So I went over to my friendly Navy recruiter and she said that, based on my experience, they would make me an O-2--lieutenant j.g.–and allow me to go to the Naval Hospital at Annapolis. So my first duty assignment was at the Naval Hospital Annapolis, MD.

Did you have to go to Newport for orientation?

Yes. I went to Newport for OIS [Officer Indoctrination School]. I think I went there in the summer of '77. Then we went to Annapolis and were there for 3 years, where I worked in ICU and the Medical/Surgical ward. I was then selected for the CRNA [Certified Registered Nurse Anesthetist] program. The Navy Nurse Corps sent me to George Washington University for a year, then a year at Portsmouth for a clinical internship. My first duty station as a CRNA was Naval Hospital Pensacola, FL. The first duty station was often one in which you did difficult cases by yourself in preparation to be seen as a person who could practice independently in an operational environment at sea or with the Marines.

So they were preparing you for that?

Yes. The senior physicians and CRNA's did not articulate that, but they were.

Female nurses weren't assigned to ships at that time.

Correct. At that time, until about the early '70s or mid-'70s, dental officers were administering anesthesia aboard aircraft carriers. Dental officers had a shore program for training in anesthesia as part of their dental residency. At some point, it was decided that the

Navy should have nurse anesthetists or physician-anesthesiologists at sea to handle anesthesia rather than the dentists. That's when the first CRNAs started going to sea. I was one of the first.

What was your first assignment?

On board the USS *America* [CV-66] as a TAD anesthetist. I joined the ship in the Indian Ocean with a general surgeon, CDR James Fitzgar. We flew from Pensacola halfway across the world and joined the *America* in the Indian Ocean. We were there for 6 months and did a lot of interesting cases. I could certainly see the need for assigning a CRNA there in support of the ship's company and the surgeon. It was necessary to have a skilled, educated provider doing anesthesia on board the ship.

And that wasn't your last ship, either.

It was my first ship. If you counted up the number, I've probably been on 20 platforms on which I've done anesthesia, either as ship's company or TAD.

Where did you go from the *America*?

I went back to Pensacola. Because I enjoyed the professional challenge on *America*, I decided to compete for a PCS CRNA billet role on a ship. In 1986 I was selected to go to USS *Nimitz* [CVN-68], which had a requirement for a CRNA. I relieved CDR Joe Norrick, NC, USN. In that job, I was also practiced as a nurse intensivist in the ICU, ran the ward, and oversaw the medical training and medical response teams.

It was a great ship's company. The Medical Department had a superb leader and teacher in CAPT Conrad Dalton, MC, USN. The ship had a lot of time underway, and I was privileged to be in that job. There were many clinical challenges. I learned the ship and how it worked as a platform for power projection. It was a great experience.

What was your next assignment?

I transferred to the PCU (pre-commissioning unit) for USS *Theodore Roosevelt* [CVN-71]. They were just building the ship at that time and I was the first anesthetist assigned to a pre-commissioning unit. It was an opportunity to build the ship from the keel up, assist in the development of the medical department, and help to train the ship's company as they came aboard.

What were your specific responsibilities?

Everything that had to do with the medical department was in our area of responsibility from training to educating the crew and ship's company on medical procedures, setting up the 3 bed ICU, the 40 bed ward, the 6 battle dressing stations, obtaining the equipment and medications, setting up the operating room, and responding to medical emergencies inside the nuclear power plant—a huge responsibility on this 5,000-man ship. The Medical Department was led by CAPT Gil Vasquez a seasoned physician and flight surgeon. He has also pre-commissioned the Carl Vison. Se he came to the TR with a wealth of knowledge that he shared every single day.

So you were working in the shipyard in a hard hat.

Absolutely. The shipyard is a challenging, and dangerous environment in which Sailors must work but it was something we had to be done to allow the ship operate safely and effectively when it got underway.

Did you stay aboard after the ship was commissioned?

Yes, for a year. But before that, I was part of Fleet Surgical Team Two as its CRNA. We got underway on USS *Saipan* [LHA-2] and USS *Shreveport* [LPD-12] for contingency operations within some areas of the world in crisis at that time. Sea mines were being dropped in the Red Sea and the ship responded to that situation.

What was your next assignment?

I was on the PCU for the USS *George Washington* [CVN-73].

Was the experience pretty much the same as it had been for *Roosevelt*?

It wasn't as intimidating as the first time around because I was more familiar with the environment. Therefore, I was more efficient and effective in getting things done.

Did you remain with the ship?

For about 3 months after commissioning.

At some point, you had an affiliation with the *New Jersey*.

Yes. I was the anesthetist during the last WESTPAC deployment of the USS *New Jersey* [BB-62]. It was in the late '80s. Wooden decks, big ship, big guns. We went through the Straits of Hormuz into the Persian Gulf. We stopped in Dubai. Being in a WWII battleship environment was remarkable. As a matter of fact, during this deployment, the *New Jersey* was the first battleship after the *Iowa* accident to fire its 16-inch guns.[1] The commanding officer had the entire wardroom come in and listen to the pre-fire briefs. So at that time in my career, I knew as much about firing a 16-inch gun as anyone else in the Navy. It was a remarkable education. It was the CO's philosophy of having everyone in the Wardroom understand all elements of the process. Although the causes of the *Iowa* accident were not known he thought it would be prudent to have everyone aware of the proper procedures. So we went step by step on how to fire the 16-inch guns.

So you got to see 16-inch gun practice.

Yes. Once we had a few good "shoots" completed the CO allowed a few of us to observe the 16" gun firing from outside the skin of the ship. I was allowed to observe from the O-11 level on the *New Jersey*. Seeing and feeling those guns fire broadside simultaneously was a remarkable and unforgettable experience. That's why I don't have any hair now.

During your career you were assigned to Naval Hospital Guam.

Yes. I assigned as Director of Nursing flowing graduation from the Naval War College. This was the first time in recent memory that a nurse anesthetist had become Director of Nursing. I had a great staff and they allowed me to be successful. It was one of the best assignments I've ever had in that the nursing component was involved in every element of the hospital. I was engaged in everything from emergency medicine, to ICU, to medical surgical

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1 During a training exercise in April 1989, the center gun on USS *Iowa*'s (BB-61) turret two exploded, killing 47 men.

nursing, to the executive steering council. It was a remarkably wonderful experience to have been Director of Nursing.

The World War II commemoration was going on at that time and there were veterans visiting Guam.

Indeed. In fact, I was the key element at the hospital in caring for the veterans returning. I coordinated that effort from Navy medicine's perspective. We dedicated a whole ward that would have allowed us to take care of the veterans if they became ill while they were on Guam for the commemoration. Remarkably, we didn't have a single admission. And this was out of all those veterans and their spouses--who were between 75 and 85 years old--returning to Guam in a hot environment. I think it proved their mettle as combatants during the liberation of Guam in 1944. They were just as strong and hardy as they were back then. But we were ready with a 50-bed ward for them just in case.

Where did you go after Guam?

I was asked to be professor of National Security Decision Making, Policy Making and Implementation at the Naval War College. And I taught that subject in Newport for 2 years.

Do you know why you were selected for that job?

I was a student at the War College a few years before and the senior faculty have a selection process for recognizing potential military professors. If you are interested in being an instructor, they identify you and you are interviewed and so forth. I was selected as a potential candidate to be an instructor at the War College but Navy Medicine and the Navy Nurse Corps wanted me to go to Guam so I went there first. Then the offer was made again through Navy Medicine for me return to the Naval War College as a faculty member after our Guam tour. So that happened and I taught policy making and implementation in the National Security Decision Making arena for 2 years. In fact, I've been volunteering as a professor in national decision making for the last 9 years. I've taught in the continuing education department for the last 9 years. It's called the College of Distance Education. I've taught in Naples, Guam, Guantanamo, and now at the Washington Navy Yard.

The War College education and being a faculty member allows the individual a perspective of understanding the big picture and then aligning your organization and your people to understand why we exist as the Navy Medical Department in support of a greater effort in the Navy and the a nation.

While I was at the War College, I created an elective called "Unconventional Warfare and Uncertain Times." And remember this was in 1995 when biochemical warfare was just beginning to become important as far as a strategic component of War College. I developed this elective because I thought the line officer needed to have some understanding of chemical and biological warfare. The offer was oversubscribed every time I gave it because the war fighter felt that this was something they needed to have so they could align their assets to this new threat that was on the horizon.

It was taught over three tri-mesters and taught three different times and always oversubscribed, which was a testimony to how important the war fighters thought this was.

I was selected for captain at the War College and was subsequently selected as executive officer for Naval Hospital Naples. And we went to Naples as executive officer of a very

dynamic Navy medicine environment in a very dynamic part of the world. It is one of our favorite places to have been.

The Italian culture is made up of wonderful people, family-centered with every meal being a treat. I had the opportunity to begin to close down the old naval hospital and build the new naval hospital. I was the CO's representative on the Source Selections committee for the new hospital.

I understand they ran into a lot of Roman artifacts while excavating for it.

I believe the builders incorporated an artifact within the lobby of the hospital. That was a decision that was made by the antiquity commission. If you want to build on historic Italian sites preservation of antiquity is a requirement.

During my tour in Naples, I worked for two great COs, CAPTs Spier and Adams. They allowed me to actively observe what good leadership was in Navy medicine and the Navy. The COs allowed me to have a great influence on the way the command was run. And that experience as their XO allowed me to be a more successful CO.

Where did you go from there?

I was selected to became the commanding officer of the Naval Hospital at Naval Base Guantanamo Bay, Cuba I think I went down there to close the place down. Guantanamo had lost its strategic importance as the Cold War was over and Fleet Training Group moved to Jacksonville. Guantanamo was just a sleepy little place that had about 5,000 residents. The hospital was there to take of the base population to include the Cuban exiles.

So that was a wonderful opportunity, and my time there was critically impacted by the events of 9/11. GTMO then became the focus of world attention when the Joint Task Force Guantanamo was set up as Joint Task Force 160. I became the Joint Task Force Surgeon for the detainee mission.

How did you learn you were going to do that?

Someone gave me a call and said, "You've got it." The commanding general, Brigadier General Mike Leonard, USMC and I were classmates at the Naval War College. The base commander, CAPT Bob Buehn, USN was also a classmate so we all knew each other.

Then you were the first nurse to be a task force surgeon.

Yes, I believe so. I was the first nurse anesthetist to be a commanding officer and an XO, and the first nurse to be a joint task force surgeon. The surgeon title is simply a title, not a skill. I don't do surgery. But it was a title that allowed me to have the opportunity to exercise oversight over all aspects of medicine for both the detainees and the Joint Task Force. I had responsibility for the Marine Corps medical components, initially, and then when the Army and National Guard fell into the mission, I kept the title and continued to have that responsibility to take care of the soldiers and the detainees.

In a talk you gave several years ago at AMSUS, I recall you saying that taking care of migrant patients was easy because they were a friendly population that appreciated the healthcare. With the detainees, you had a group that were not only unfriendly but hostile.

Yes. The detainees were initially hostile to the guards and the medical staff. And that was a component of healthcare delivery that I had not been involved with before. But, that being

said, it didn't affect the quality of care the detainees experienced. Many detainees came in injured and sick and they got the best possible care we could deliver. The standard of care we gave the detainees was at the level of the care we would give an American service member. We gave them first-rate care despite their hostility toward the United States.

You had to come up with a special regime for treating these people, considering that now, even your healthcare providers were at risk.

That's right. We were very conscious of the fact that they wanted to hurt Americans. Therefore, the patients were not seen in isolation in a private area. We always had a guard with the provider as they were examining the patient. We were also certain there were safeguards in place when the detainees were being seen. That being said, I can't recall any aggressive behavior of a detainee toward a healthcare provider. They appeared to welcome the care they received.

As I recall, that mission was set up fairly quickly.

Overnight. Within 2 weeks we developed Camp X-Ray and the medical component, which was quite rudimentary but acceptable. Then we built a Navy hospital for the detainees in 4 months. So we had a brand-new hospital there for them when we moved them to Camp Delta. We built an ICU in the Naval Hospital in Guantanamo for really sick detainees who needed intensive care post-surgically or medically. That's been used 20 or 30 times as an ICU. Prior to that, anyone who was very sick or seriously injured was air evacuated to the United States.

What kinds of diseases did you see in the detainee population?

Leishmaniasis, malaria, and systemic diseases they had had all their lives. We had fresh injuries from the battlefield. We did amputations, enucleations–many significant medical and surgical challenges. And all the detainees did very well medically and surgically.

Was it also your responsibility to see to their mental welfare?

We developed and built a mental health ward--Delta Block--which took care of the most seriously mentally ill of the detainees. We had a physician and a mental health staff engaged full-time in the care of the mentally ill.

How long were you there in that role?

The first 18 months of the mission.

Where did you go after that assignment?

The Surgeon General invited me to BUMED and become Navy Medicine's led on the Medical Cross-Service Group in the 2005 BRAC arena. It was another remarkably interesting job in that we were transforming military medicine in the joint arena into something that will occur in the future. It involved coordinating and consolidating assets to become a different type of military medical department based on synergies of each service so we become better and more efficient. And I think we succeeded.

Was that a difficult transformation for you to make from the healthcare arena to this futuristic planning or did your War College experience help you.

It helped, plus we had superb Army and Air Force O-6s who were very well seasoned in their professional backgrounds. And, Navy Medicine assigned CDR Nancy Hight, MSC to our team. She made a huge difference and very positive difference to the analytical process. We knew we weren't going to be liked necessarily and we needed to set the agenda to become something we were not at that time, which was to become more alike than unlike. Strategically, it was a very positive experience. Our Surgeons General agreed to agree that this was the way it was going to be. So there were difficult decisions to be made but they were based on the country's need for efficiency and effectiveness in the delivery of healthcare to our beneficiary population.

Were they all equal players?

There was robust debate but everyone at the table was equal.

Then you were selected to head this medical treatment facility?

Not quite. There was an interim. I was selected as the Deputy Commandant Naval District Washington. I was asked to do this by the Commandant Naval District Washington at the time. RDML Jan Guadio. He arranged with our Surgeon General for me to leave BUMED and work for him. BRAC was over and I became the Deputy Commandant of Naval District Washington, the first time a staff corps officer had become a deputy commander of any of the Navy Regions under.

What were your responsibilities in that new position?

I was responsible for 51,000 military and civilian personnel, $18 billion dollars of plant coordination: 18 installations. So I was XO for the admiral at Naval District Washington. I worked at the Washington Navy Yard and was 50 yards from my home. I still live there.

That was an 18-month tour and then came the opportunity to become commanding officer of the medical treatment facility on USNS *Comfort* [T-AH 20]. This has been one of the most remarkable jobs in my Navy career in that it combines everything I love about the Navy: medicine, being on a ship, being operational, taking care of our fellow human beings. It's been the capstone of my career.

Not a difficult transition seeing that you spent how many years at sea?

Six total cumulative years at sea.

So this was a natural transition for you.

Yes. The criteria for selection for command on *Comfort* was post MTF command. So both CAPT Joe Moore and I, who is my counterpart on *Mercy*, had medical treatment facility fixed tours as commanding officers. As commanding officer of a medical treatment facility we know what supposed to happen in a hospital. So whether it's on a ship or fixed, the hospital piece still stays in place. CAPT Moore and I are very careful in articulating that we're not driving the ship. We're responsible for the MTF on this ship.

The MTF on Comfort is a hospital housed in a ship's hull.

Yes. We have three primary missions: taking care of our service members who are injured in war. We have a disaster relief mission, which means responding to a national disaster within our domestic borders, or overseas like *Mercy* did in the tsunami relief and as we did in

Katrina, and we also have the humanitarian assistance mission that *Mercy* has been participating in Indonesia, the Philippines, and Bangladesh.

So this is what these two hospital ships are being used for.

Yes.

Both vessels were designed for the Cold War but obviously they've morphed into something else.

With *Mercy* and *Comfort*, these platforms are able to be used in areas of the world we never thought they'd ever be functioning in. *Comfort* was able to provide care after Katrina. *Mercy* did so following the tsunami and in its current mission in providing humanitarian assistance. Both ships have proven to be remarkably versatile far beyond expectations. So these platforms used as a soft power projection of the United States in areas of the world that require this kind of assistance will make a huge difference in our childrens' and grandchildrens' lives in that we will have affected people at a point in their lives where health care is important. And they will think favorably of our nation in our ability to provide health care in their communities.

You were recently out with *Mercy* in Indonesia. What was your purpose in going there?

My view and CAPT Moore's view is that we need to have the two hospital ships function very similarly. So I deployed with *Mercy* to participate in that mission to understand the complexities in developing a successful mission with humanitarian assistance as a primary goal. This mission the *Mercy* did--and CAPT Moore let me be part of it--integrated NGOs such as Project Hope, Operation Smile, Aloha Medical Mission, and Army and Navy healthcare professionals in order to provide a seamless provision of healthcare both on the ship and ashore. Being able to be part of that allowed me bring that experience back to *Comfort* so if we get underway for a similar mission next year we will be able to do it successfully.

What mission do you anticipate for the ship next year?

There's nothing specific but if we're called upon by National Command Authority to do any mission, we're ready.

Today, *Comfort* is undergoing an exercise called COMFEX. How often do you hold these exercises?

Quarterly. We bring people who haven't been on board a ship before to familiarize them with the ship's environment for the first 2 days. Then the last 2 days is an orientation into the departments in which they will be working so they will be ready to come aboard, get underway, and provide the care almost immediately.

Will it be done the same way as had been done during the first Gulf War or the most recent war in Iraq? Will the crew board here in Baltimore?

Some will get aboard here but we may meet the others at a port of embarkation in the United States or overseas. We would give the providing hospital additional time because it takes us a few days to get to where we're going to be.

So, the role of these ships in solely supporting the war fighter has really changed.

It's evolving and becoming more flexible than anyone ever imagined. CAPT Moore and his crew and CAPT Ellingham and his crew on *Comfort* have proven that point dramatically.

I recall talking with you just after you were selected to command *Comfort* and you were quite thrilled. I'll bet you still are.

I'm privileged to be the commanding officer of the MTF on this ship!